Gwynedd-Mercy College Medical History Form

Name ______________________________________ **Sex** _______ **Age** _____ **Date of Birth** _______________

Year of Study FR SO JR SR Grad **Sport** (Student-Athletes only)____

Home Address ____ **Home Phone #** _________________________

Residence Hall______________________________ **RM #** ___________ **Cell Phone #** __________________________

Family Physician ____ **Physician Phone #** __________________________

Emergency Contact
Name ___________________________ Relationship _____________Phone (H)________________(W or C)_______________

Personal History

1. Current Illness/Injury	Y	N	10. Frequent or Severe Headaches	Y	N
2. Hospitalized/Surgery	Y	N	11. Numbness or Tingling in your arms, legs, hands, or feet	Y	N
3. Allergies	Y	N	12. Stinger, Burner, or Pinched Nerve	Y	N
4. Have you had a severe viral infection (ex. Mononucleosis, myocarditis) within the last month?	Y	N	13. Skin Problems (ex. Acne, fungi, warts, rash, itching, blisters	Y	N
5. Asthma/Bronchitis	Y	N	14. Experience during or after exercise:		
			Tire more quickly than your friends	Y	N
Specify: __________________________________			Dizziness	Y	N
			Chest Pain	Y	N
			"Racing Heart"/Skipped Beats	Y	N
			Coughing/Wheezing/Diff. Breathing	Y	N
6. High Blood Pressure	Y	N	15. Have you ever become ill from exercising in the heat?	Y	N
Heart Murmur	Y	N			
High Cholesterol	Y	N			
7. Previous Illness/Injury	Y	N	16. Do you feel stressed out?	Y	N
			Have you ever felt depressed?	Y	N
			Have you ever sought help for depression?	Y	N
8. Head Injury	Y	N	17. Vision Problems/Corrective Lenses	Y	N
Dates _________________			Please circle:		
Loss of Consciousness	Y	N	Contacts Glasses Both		
Loss of Memory	Y	N			
9. Seizures/Epilepsy	Y	N	18. ***Females Only***:		
			Date of 1st Menstrual Period _______________		
Date of Last Episode __________________			Date of Most Recent Period _______________		
			Ave. time between Periods _________________		
			Number of Periods per Year ________________		
			Longest time between Periods this year ________		

Please specify to any items answered "YES":
____

____

Family History
Has anyone in your immediate family (parents, siblings, grandparents) had any of the following:

Heart Disease	Y	N	Diabetes	Y	N
High Blood Pressure	Y	N	Cancer	Y	N
Stroke	Y	N	Tuberculosis	Y	N
Sudden Death (before age 50)	Y	N	Asthma	Y	N
Epilepsy	Y	N	Gout	Y	N
Migraine Headaches	Y	N	Marfan's Syndrome (Heart)	Y	N
Eating Disorder	Y	N	Sickle Cell Anemia	Y	N

Please specify to any items answered "YES":

____

____

Medications/Supplements – Please list any medications or supplements (ex. Creatine, Metabolife) you are currently taking

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Record the dates of your most recent immunizations (It may be necessary to contact your primary care physician to obtain accurate dates for each vaccination):

***** Required prior to Beginning of Classes*****	1st	2nd	3rd	4th	5th
Measles, Mumps, Rubella (MMR) - Must have 2 injections, both **after 1st birthday & at least 30 days apart**					
Polio - Minimum of 3 doses for all students 18 and under					
Tetanus/Diptheria (DPT) - 3 or more doses required					
DPT/DTaP/Td - tetanus booster **must be within last 10 years**					
Hepatitis B - series of 3					
Varicella (chicken pox) - Date of disease **OR** If no history of disease, 2 doses required after age 13					

Tuberculosis Screening – (ALL students are required to show freedom from Tuberculosis within the past 12 months)

1. Tuberculin skin test:

Date given:_______/_______/__________ Date read:_______/_______/__________

Result___________________________ (Record actual mm of induration, transverse diameter; if no duration, write "0")

Interpretation (based on mm of induration as well as risk factors): positive_______ negative_______

2. Chest X-Ray (required if tuberculin skin test is positive) result: normal_______ abnormal_______

Date of chest X-Ray:_______/_______/__________

Meningitis

Vaccine and Booster are required of all Gwynedd Mercy Housing students

Date of vaccination:

Menomune______/_______/__________ Menactra_______/_______/__________ Booster_______/_______/__________

Meningitis Information Response – Required of all resident students **(Check either #1 or #2)**

1. __________ I have had the meningococcal meningitis immunization.
2. __________ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine and have decided that I will **NOT** obtain immunization against meningococcal meningitis disease.

Signature of Student Required:____

(Or Parent/Guardian if student is under age 18)

Clinician'c initials that information above is correct__________

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Student ____ **Date** ___________________

Signature of Parent/Guardian (if under 18) ____ **Date** _______________

Gwynedd-Mercy College Physical Exam
Medical Evaluation

Name: ________________________________

Vital Signs:

Ht. _________ **Wt**. ___________ **BP**: _____________ **Pulse**: ___________

Vision: *Right*: 20/___ *Left*: 20/___ *Corrected*: Y N *Pupils*: Equal Unequal

Medical Findings

Appearance	Normal	Abnormal	*Comment*: __________________________
Eyes/Ears/Nose	Normal	Abnormal	*Comment*: __________________________
Lymph Nodes	Normal	Abnormal	*Comment*: __________________________
Pulses	Normal	Abnormal	*Comment*: __________________________
Heart/Lungs	Normal	Abnormal	*Comment*: __________________________
Abdomen	Normal	Abnormal	*Comment*: __________________________
Genitalia (Males)	Normal	Abnormal	*Comment*: __________________________
Skin	Normal	Abnormal	*Comment*: __________________________

Clearance Level:

Cleared **Not Cleared** (Reason) ____________________________________

Cleared after Evaluation/Rehabilitation for the following:

Recommendations/Limitations:

____

____

____

Physician's Signature: ____

Date: _______________

I hereby give permission to the Student Health Center practitioners or to a physician of their choice, to prescribe necessary medication and/or perform treatments or operations necessary in the best interest of my health. Moreover, I understand that it is the policy of the Gwynedd Mercy Healthcare community to notify my parents or guardians of any serious illness or injury.

____ ____

Signature of Student **Date** **Signature of Parent/Guardian** **Date**
(if student is a minor)

Gwynedd-Mercy College Physical Exam
Musculoskeletal Evaluation

Name: ______________________________

Musculoskeletal Findings

Neck/Back	Normal	Abnormal	*Comments*: ____________________
Rt. Shoulder/Arm	Normal	Abnormal	*Comments*: ____________________
Lt. Shoulder/Arm	Normal	Abnormal	*Comments*: ____________________
Rt. Elbow/Forearm	Normal	Abnormal	*Comments*: ____________________
Lt. Elbow/Forearm	Normal	Abnormal	*Comments*: ____________________
Rt. Wrist/Hand	Normal	Abnormal	*Comments*: ____________________
Lt. Wrist/Hand	Normal	Abnormal	*Comments*: ____________________
Rt. Hip/Thigh	Normal	Abnormal	*Comments*: ____________________
Lt. Hip/Thigh	Normal	Abnormal	*Comments*: ____________________
Rt. Knee	Normal	Abnormal	*Comments*: ____________________
Lt. Knee	Normal	Abnormal	*Comments*: ____________________
Rt. Foot/Ankle	Normal	Abnormal	*Comments*: ____________________
Lt. Foot/Ankle	Normal	Abnormal	*Comments*: ____________________

Clearance Level:

Cleared **Not Cleared** (Reason): ___________________________________

Cleared after Evaluation/Rehabilitation for the following:

____

Recommendations/Limitations:

____

____

Physician's Signature: ____

Date: ________________

Gwynedd-Mercy College Athletic Training/Sports Medicine

Gwynedd-Mercy College
Insurance Information Verification Form

Name:____

Date of Birth:____________________ Sport (Student-Athletes only):____________________

SSN: ___________________________ Year: Fr So Jr Sr Grad

Parent/Guardian Name(s):____

Home Address: ____

____

Home Phone: _______________________ Work Phone:____________________

Cell Phone: _______________________ Work Phone:____________________

Policy Holder Name: ____

Relationship to Student: ____

Address: _________________________________ Home Phone: __________________

_________________________________ Work Phone: __________________

Insurance Company Name: ____

Address: ____

____

ID/Policy #: ______________________________ Group #:______________________

Member Services Phone: ____

Effective Date of Policy: ____________________ Expiration Date: _______________

Policy Lifetime Max. Limit:____

Policy Deductible: ________________________ Policy Co-Pay: ________________

Primary Physician: ____

Address: ____

____

Office Phone: _______________________ Office Fax: __________________________

Does your policy cover athletically related injuries? **YES** **NO**

Does your policy require a second opinion before surgery? **YES** **NO**

Does your policy require a referral from your primary physician? **YES** **NO**

ALL FORMS MUST BE COMPLETED AND RETURNED BY AUGUST 1, 2011.